Nutrition Works LLC

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Patient Registration
Please fill out and bring to your first visit.

(Please Print)

PATIENT INFORMATION					
Patient's Last Name: First: Middle:					
Street address:			Parent's Name (Minors):		
P.O. Box:	City:		State:	ZIP Code:	
Home Phone:	Work Phone:	Cell Phone:	Birth date: / /		Sex: ❑ M ❑ F
Occupation:	Email Address:		Can we send information about nutrition or cooking classes to your email address? ❑ Yes ❑ No		
Primary Care Physician:	Name, address and phone # of practice:				
Specialist (if applicable):	Name, address and phone # of practice:				

BILLING AND INSURANCE INFORMATION		
Insurance Company Name:	ID or Policy Number:	Group/Code:
Subscriber's Name:	Subscriber's Employer:	Subscriber's Birth Date / /
Patient's relationship to subscriber:	Are nutrition services coved by your insurance?	How many visits?
Do you have any other insurance? ❑ Yes ❑ No		

Health History

Name:	**Birth Date:**	**Age:**	**Today's Date:**

List your main health concerns in order of importance:	**Duration of problem:**
1.	
2.	
3.	

What are you hoping to get out of your visit(s) with the dietitian?

Circle or write in your past or present medical conditions and/or symptoms:		
Heart disease	Vitamin deficiency	Gastric reflux (GERD)
High blood pressure	Anemia	Celiac disease
Pre-diabetes	Osteopenia	Diverticular disease
Diabetes	Osteoporosis	Constipation
PCOS	Kidney disease	Diarrhea
High triglycerides	Kidney stones	Lactose intolerance
High cholesterol	Cancer	Irritable bowel syndrome (IBS)
Hypothyroidism	Eating disorder	Ulcerative Colitis
Gallbladder disease	Anxiety	Crohn's disease
Migraine headaches	Depression	Food allergies/sensitivities
Other:		
Significant family history?		

Weight history:		
Height:	Current Weight:	Most Weight:
Lowest weight in past **5** years:	Lowest weight past in past **10** years:	
Recent weight loss or gain? Yes No	How much? Over what time period?	Was recent loss/gain intentional? Yes No
Your preferred weight:	Are you looking for assistance with weight management? Yes No	
If yes, what approach has worked well for you in the past?		

Please list all prescription or over-the counter medications, supplements and herbal preparations:						
Name:	Dose:	Start Date:		Name	Dose:	Start Date:

--OVER--

Exercise	
How often do you exercise? Never Rarely Occasionally Frequently Every Day	
What type of exercise do you do?	How many minutes/hours per week (total)?
How long have you followed your current exercise routine?	How long has it been since your last check-up with your physician?
Has your doctor advised you to exercise? Yes No	Have any of your doctors placed restrictions on the type or amount of physical activity you should do? Yes No If yes, what are your restrictions?

Health and social habits:	
Occupation:	Who does the shopping and cooking at home?
How are your cooking skills? good fair poor	Do you bring lunch to work? Yes No Sometimes
Number of times per week you eat food from a restaurant, fast-food, cafeteria or take-out? Include snacks, breakfast, lunch and dinner:	Where?
Do you smoke? Yes No Quit _____ years ago	Do you salt your food? Yes No
Do you drink coffee or tea? Yes No How much? How do you take it?	Do you drink alcoholic beverages? Yes No What and how much?
Do you drink soda? Yes No What kind and how much?	Do you have any concerns about disordered eating thoughts or behaviors? Yes No
How many times a day do you eat?	Do you eat during the night?
If you are seeking assistance with weight management, what factors do you feel have contributed to your weight?	What are potential barriers to your success with changing your diet or lifestyle?

--OVER--

- Record all foods and beverages consumed for four days and nights before your visit.
- Describe the type of food, brand, and how it was prepared.
- List the amount consumed using cup, ounces, inches, etc.
- Don't forget snacks and beverages, and extras such as cream, sugar, margarine or mayo.

Circle type of day: Workday Non-Workday Holiday Prep: Write in where the food was prepared; Home-prepared (H), Restaurant (R), Take-out (TO) or Convenience Food (C)			Circle type of day: Workday Non-Workday Holiday Prep: Write in where the food was prepared; Home-prepared (H), Restaurant (R), Take-out (TO) or Convenience Food (C)		
Time	Prep	Food Amount	Time	Prep	Food Amount

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